



# Annual Health Information Form 2022-23

*This is confidential information and will be shared with school staff on a need-to-know basis*

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

**Please check all CURRENT health conditions of your student:**

ADD/ADHD <input type="checkbox"/>	Autism <input type="checkbox"/>	Developmental delay <input type="checkbox"/>	Migraines/headaches <input type="checkbox"/>
Seasonal allergies <input type="checkbox"/>	Bowel/bladder <input type="checkbox"/>	Head injury/concussion <input type="checkbox"/>	Seizure disorder <input type="checkbox"/>
Asthma <input type="checkbox"/>	Bone/joint <input type="checkbox"/>	Hearing loss <input type="checkbox"/>	Stomach issues <input type="checkbox"/>
Food allergies <input type="checkbox"/>	Depression <input type="checkbox"/>	Other: _____	

Please describe any health conditions in greater detail. Include any hospitalizations or surgeries (month/year):  
\_\_\_\_\_

List any other medical conditions which may impact your student's learning at school, including dietary or physical restrictions:  
\_\_\_\_\_

Does your student currently take any routine medications? **Yes**  **No**  If Yes, list the medications your student takes:

Medication/Dose/Time: \_\_\_\_\_

Medication/Dose/Time: \_\_\_\_\_

Will your student be taking any medications at school? **Yes**  **No**

**Please note:** A physician order is required for **all** medications to be administered at school (including over the counter medications). Students are not permitted to self-carry medication without a physician's order, parent and school nurse approval. Please contact school health office for more information at: 719-495-5249

Does your student have a **significant life threatening allergy**? **Yes**  **No**

If Yes, list the specific allergy, reaction/symptoms and date (month/year) of last reaction: \_\_\_\_\_

Will you be providing the school with rescue medication, such as Epinephrine, for the significant allergy? **Yes**  **No**

If rescue medication is NOT provided, 911 will be called if an emergency arises.

Does your student wear glasses/contacts? **Yes**  **No**  Vision Diagnosis: \_\_\_\_\_

Date of last vision exam by an eye doctor/eye specialist: \_\_\_\_\_

Does your child have Medicaid? **Yes**  **No**

*If your student does NOT have health insurance, please call Falcon Peak Health Center: 719-344-6247 for more information.*

**Emergency Care Parent Permission:** In case of serious illness or injury, first aid will be rendered in accordance with school policies. If ambulance service is necessary, the parent/guardian must assume financial responsibility. If parent/guardian cannot be reached in the event of such emergency, your student will be sent to the preferred hospital listed above, or to the medical facility determined by Emergency Medical Service (EMS).

Student's Physician and phone number: \_\_\_\_\_

I (parent/guardian), give the school permission to contact my student's doctor to obtain immunization records. **Yes**  **No**

Parent/Guardian Signature: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency Contact Phone:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_